CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS
Sitting/Acting as Board of Health

Policy Session Worksheet

Presentation Date: 5/10/2023 **Approx. Start Time:** 10:00am **Approx. Length:** 30 minutes

Presentation Title: Opioid Settlement Funds – Progress Update on Community Engagement Efforts and Establishing BCC Funding Priorities

Department: Health, Housing & Human Services

Presenters: Rodney Cook, H3S Director and Philip Mason-Joyner, Public Health Director

Other Invitees: Stephen Madkour, County Counsel

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?

Staff will present a progress update on community engagement and outreach that has taken place since August 2022 as part of the Board adopted Opioid Settlement Framework. County staff are seeking direction from the Board of County Commissioners (BCC) on their funding priorities for the distribution of Opioid Settlement funds.

EXECUTIVE SUMMARY:

Clackamas County and several cities have received their first funding allocations to mitigate harms associated with the opioid and other drug crisis impacting our county and the nation. Approximately $2.9 million of National Opioid Settlement funding is now available to save lives and support our residents, communities and institutions impacted by substance use. Payments are expected to arrive over the next 18 years, totaling approximately $13.7 million. The exact amount is unknown due to additional settlements in-process.

Staff have been working to implement the Clackamas County Opioid Settlement Framework approved by the BCC in August of 2022. This framework serves as a roadmap to assist the Board in determining long-term planning and maximize the distribution of settlement funds. The first step of the framework was community engagement, including outreach to cities, community coalitions, partner organizations, and residents with lived experience. The next step is gathering BCC feedback on the Board's priorities for desired uses of the opioid settlement funds. The final step is to establish a multi-disciplinary Steering Committee that would develop proposed strategies and funding proposals for BCC consideration.

FINANCIAL IMPLICATIONS (current year and ongoing):

Is this item in your current budget? ☐ YES ☒ NO

What is the cost? $2,900,000 funds received to-date
What is the funding source? Opioid Settlement Funds

STRATEGIC PLAN ALIGNMENT:

- **How does this item align with your Department's Strategic Business Plan goals?**
  Improve community safety & health

- **How does this item align with the County's Performance Clackamas goals?**

  This effort aligns with the Performance Clackamas goal to *Ensure Safe, Healthy and Secure Communities*, by addressing the social determinants of health including: addiction, homelessness, lowering crime, employment, and links to critical behavioral health services.

  .

  Clackamas County's Opioid Settlement Framework aligns with the goal, to *Build Public Trust through Good Government*, by embedding community engagement, transparency, and accountability in all processes. This includes collecting feedback from stakeholders and residents through listening sessions, focus groups and interviews to identify service gaps and priorities for settlement funding.

LEGAL/POLICY REQUIREMENTS:

Clackamas County will receive $13.7 million as part of the Johnson & Johnson and the Distributor Settlements. Additional funds are likely to be available due to addition settlements being negotiated. In the National Settlement Agreement, local governments commit to use all funds, except Backstop Funds, for future opioid abatement per Exhibit E of the national settlement agreements ("Approved Abatement Uses"). Exhibit E details approved use of funds (attached).

PUBLIC/GOVERNMENTAL PARTICIPATION:

The Clackamas County Opioid Settlement Framework approved by the BCC in August of 2022 includes Community Engagement as a key activity to gather input from interested parties in this process. Below is an outline of public participation to date:

- Clackamas County residents were invited to attend listening sessions to identify service gaps and their priorities for addressing the opioid crisis.
- Staff presented to City Councils that signed onto the National Settlement agreement, including: Gladstone, Happy Valley, Sandy, Wilsonville, Canby, and Milwaukie City Councils. Additional outreach occurred to the cities of: Estacada, Lake Oswego, Molalla, Oregon City, and West Linn.
- Staff presented to local advisory boards, community coalitions, and community partner organizations to identify service gaps and their priorities for addressing the opioid crisis.
- Staff hosted focus groups to engage residents with lived experience to identify service gaps and their priorities for addressing the opioid crisis.

OPTIONS:

N/A

RECOMMENDATION:

N/A

ATTACHMENTS:

- PowerPoint Slides – Opioid Settlement Progress Update
- Community Engagement Overview of Gaps & Priorities
- Exhibit E: Allowable Uses of Opioid Settlement Funds

SUBMITTED BY:

Division Director/Head Approval _____
Department Director/Head Approval _____
County Administrator Approval _____

For information on this issue or copies of attachments, please contact Philip Mason-Joyner @ 503-742-5956

Combating the Opioid Crisis in Clackamas County:

Settlement agreement funding update

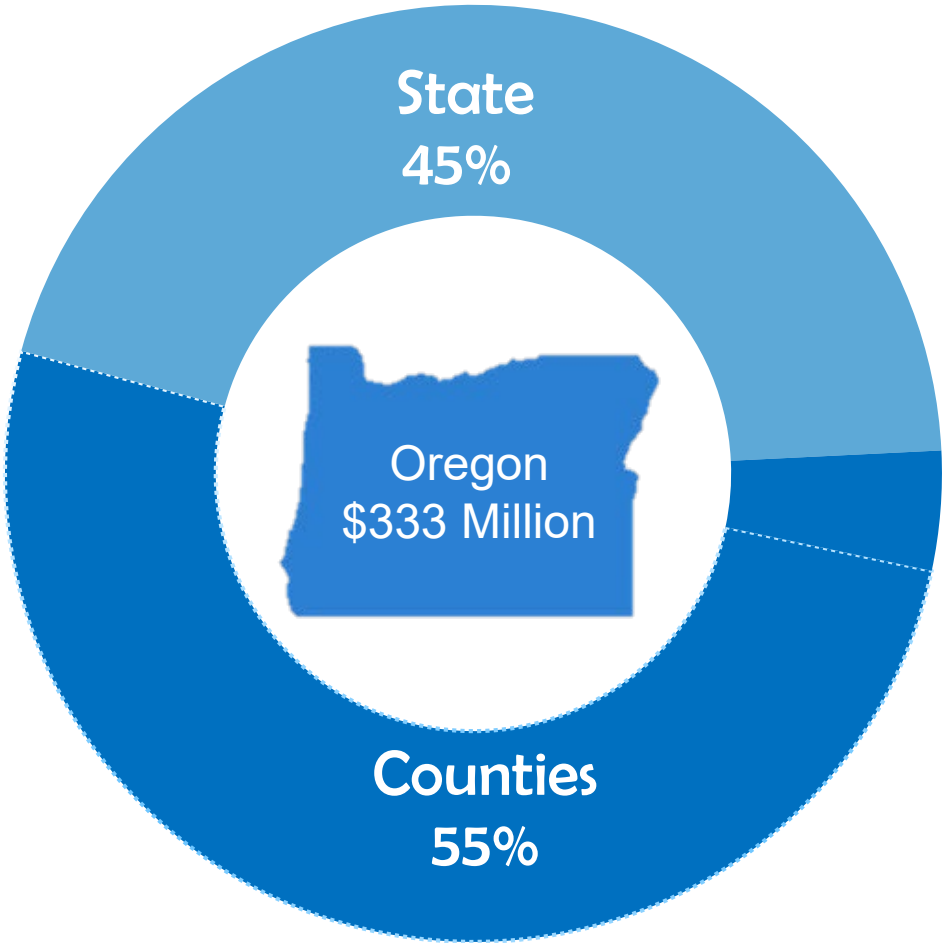
May 10, 2023

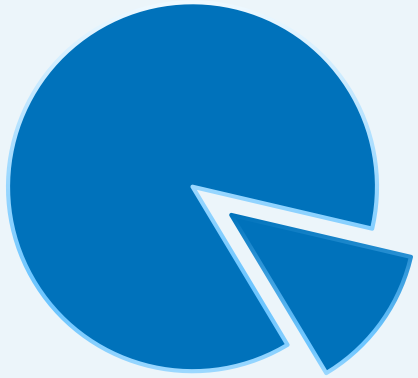
Health, Housing & Human Services
CLACKAMAS COUNTY

Agenda

1. Overview of the Opioid Settlement Agreement and local funding allocations
2. Summary of stakeholder outreach, engagement efforts and community priorities
3. Discussion of BCC priorities, the County's use of Opioid Settlement Funds and next steps.

Settlement Agreement Background





Clackamas County

$13.7 Million

- Canby
- Gladstone
- Happy Valley
- Lake Oswego
- Milwaukie
- Oregon City
- Sandy
- West Linn
- Wilsonville

FUNDING

2022

18 years

Health, Housing & Human Services
CLACKAMAS COUNTY

Allowable Uses of Settlement Funding

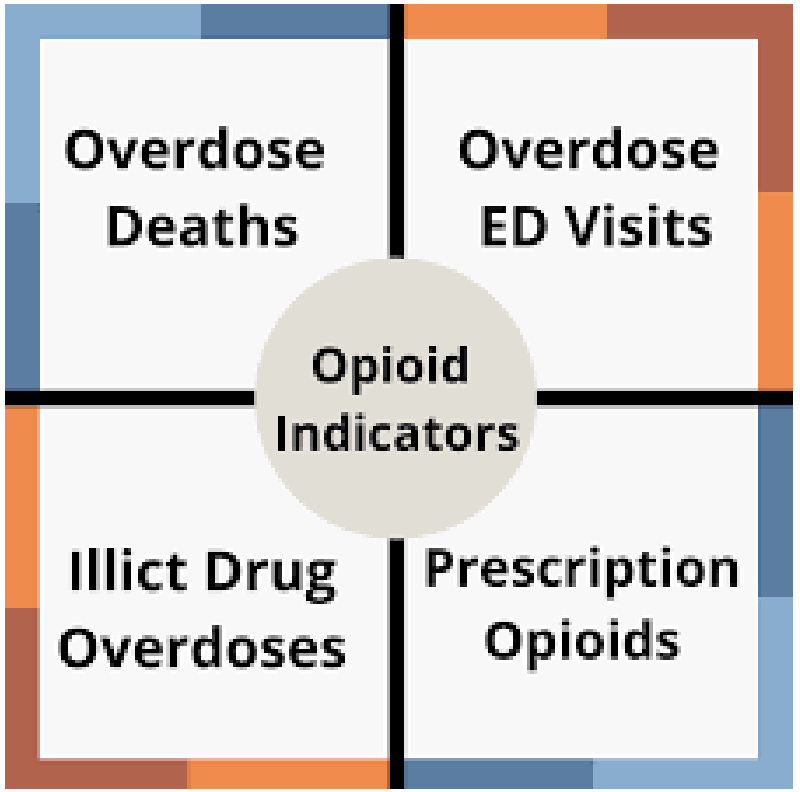
The Exhibit E of the Settlement Agreement identifies
nine core abatement strategies:

1) Targeted naloxone distribution
2) Criminal justice interventions
3) Medication for Opioid Use Disorder
4) Enrich prevention strategies
5) Linkage to Syringe Exchange programs
6) Healthcare system interventions
7) Warm hand-off program and recovery support
8) Data collection and research
9) Treatment during pregnancy & postpartum

Using Data to Inform Decisions

Public Health staff maintain a substance use data dashboard that includes key indicators of opioid harm. These numbers describe some, but not all, of the impact of opioids on the people of our county.

Data can be used to identify populations and areas of the county most impacted.



Process Timeline 2022-2023

June-22 July-22 Aug.-22 Sept.-22 Oct-22 Nov.-22 Dec..-22 Jan.-23 Feb.-23 March-23 April-23 May-23 June-23 July-23

Community & Stakeholder Engagement

Lift Up Equity & Transparency
- Host listening sessions with stakeholders and people with lived experience.
- Launch survey to identify community priorities and needs.
- Engage City Councils and provide updates on settlement.

Support Collaboration & Coordination
- Assessment and listening session findings reviewed.
- Rubric developed to score funding priorities – rubric applied.
- Recommendations made for internal and external funding distribution.

Steering Committee

Implementation
- Recommendations developed based on BCC priorities
- Adjustments made to promote sustainability.

Assessment & Evaluation

Use Evidence to Guide Investments
- Comagine Health assessment identifies Measure 110 investments and demographic gaps.
- Public Health Opioid Indicators and ongoing data collection and evaluation
- Approval of framework by BCC and ongoing annual reports.

Outreach & Engagement Highlights

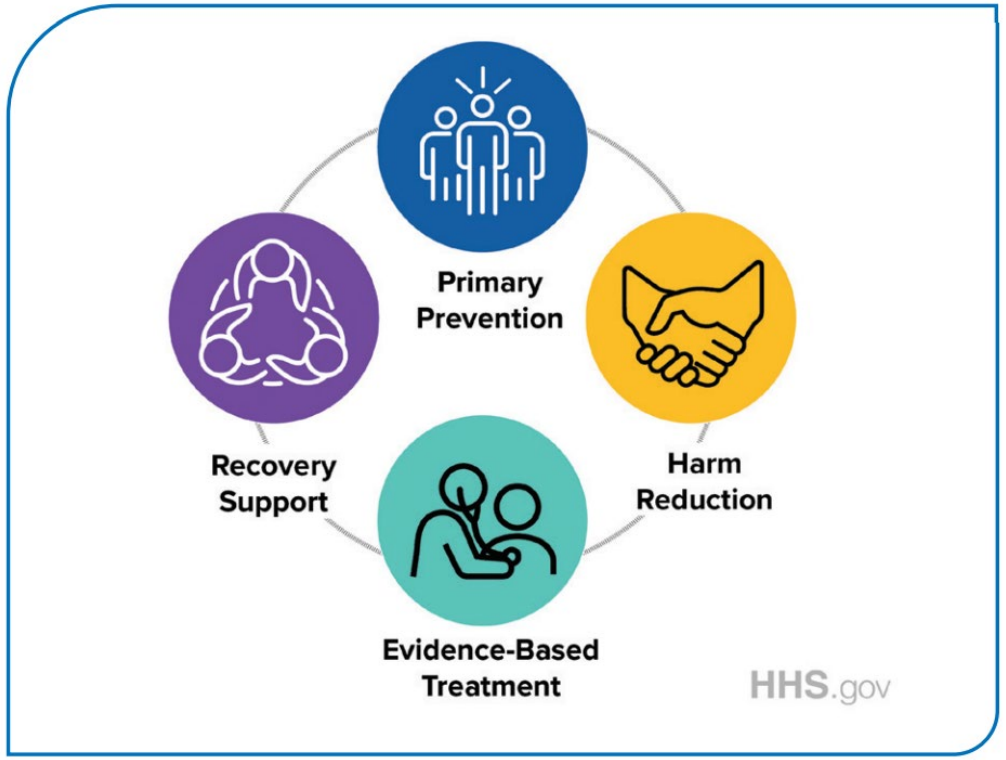
- **County Coordination**
  - Strengthened collaboration between H3S, Sheriff's Office, Juvenile Department, Community Corrections & District Attorney
- **City Engagement**
  - Presentations to Gladstone, Happy Valley, Wilsonville, Sandy, Milwaukie & Canby City Councils
  - Discussed lack of services available in Clackamas County to meet demand
  - Some have expressed interest in providing their funds directly to the County
- **Community Collaboration**
  - Raised importance of incorporating voices of lived experience in the assessment and planning process
  - Discussed barriers such as housing, mental health services, childcare, workforce, culturally relevant services, services for youth and workforce challenges

Stakeholder Feedback and Service Gaps

Community perspectives from nearly 60 local organizations serving Clackamas County were gathered to identify current service gaps and prioritize approved abatement strategies to inform settlement allocation decisions.

Common themes of existing gaps:

- Limited rural resources, culturally responsive services and reliable access to naloxone
- Capacity constraints among existing service providers and limited availability of community triage, stabilization and referral services
- Lack of mental health interventions and few service providers accepting Oregon Health Plan coverage



Community Priorities

Recovery Support:

- Invest in housing supports that integrate SUD and other supportive services
- Expand access to peer recovery centers, including support groups, social events, computer access, and other services
- Provide additional resources to help with basic needs (childcare; transportation)

Substance Use Prevention:

- Expand school-based interventions to prevent opioid use
- Remove barriers to access for youth mental health services
- Provide additional evidence-based prevention programming (parental skills, child life skills, family communication, case management)

Harm Reduction:

- Increase distribution of naloxone and improved access for priority populations
- Provide additional community harm reduction trainings and messaging to decrease stigma related to naloxone and SUD.
- Expand mobile unit resources providing referrals to harm reduction services available throughout the county

Evidence Based Treatment:

- Increase access to inpatient/residential treatments and SUD community resources in community
- Expansion of warm hand-off programs (Project Hope, Behavioral Health and First Responder co-response)
- Support crisis stabilization centers for those with SUDs, co-occurring mental health conditions, and overdoses

Development of Board Priorities & Next Steps

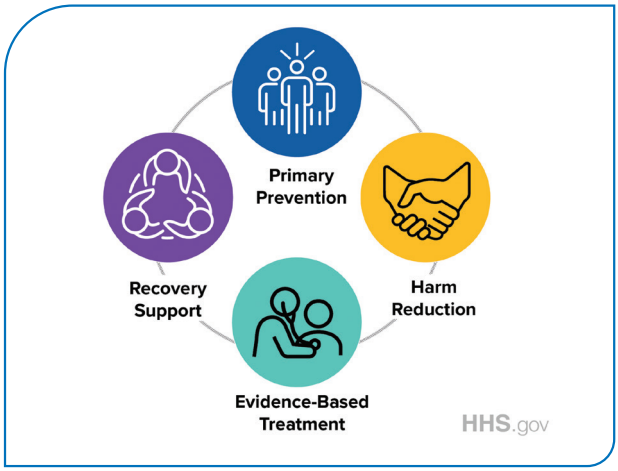
Health, Housing & Human Services
CLACKAMAS COUNTY

Strategies to confront the opioid crisis in Clackamas County

Overview of gaps and priorities

Clackamas County is expected to receive $13.7 million over the next 18 years, as stipulated by a settlement agreement with pharmaceutical companies for their actions that helped fuel the opioid crisis.

Community perspectives from nearly 60 local organizations serving Clackamas County were gathered to identify current service gaps and prioritize approved abatement strategies to inform settlement allocation decisions. Common themes of existing gaps in accessing services include workforce and transportation challenges, as well as a lack of culturally responsive services. Participants also identified the following:



Recovery Support

Current Gaps

- Overnight shelters, supportive and long-term housing and access to low-income permanent housing that embraces a harm reduction model
- Peer recovery mentors and community-based recovery centers
- Childcare and transportation, particularly in rural communities

Priority Strategies

- Invest in additional housing supports that integrate MOUD and other supportive services
- Expand access to peer recovery centers that may include support groups, social events, computer access, and other services
- Provide additional resources and assistance to help with basic needs (childcare; transportation)

Substance Use Prevention

Current Gaps

- Early childhood skills-building and education specific to fentanyl and overdose prevention.
- School-based interventions, including mentorship programs, school resource officers, drug/alcohol counselors and community parenting classes
- Incomplete local data due to inconsistent in Student Health Survey participation
- Limited rural resources, lack of mental health interventions and few service providers accepting Oregon Health Plan coverage

Priority Strategies

- Expand school-based interventions to prevent opioid use
- Remove barriers to access for youth mental health services
- Provide additional evidence-based prevention programming (parental skills, child life skills, family communication, case management)

Harm Reduction

Current Gaps

- Reliable availability and access to naloxone across all populations, particularly for rural communities, youth and non-English speakers
- Mobile harm reduction services currently unable serve the entire county
- Fentanyl-related education for the community, DHS, and law enforcement.

Priority Strategies

- Increase distribution of naloxone and improved access for priority populations
- Provide additional community harm reduction trainings and messaging to decrease stigma related to naloxone and MOUD.
- Expand mobile unit resources that offer or provide referrals to harm reduction services available in all communities throughout the county

Linkage to Treatment

Current Gaps

- Limited availability among existing services, including medications for opioid use disorder (MOUD)
- Trauma-informed transitions from the hospital, emergency departments and urgent care settings.
- Education for health care providers on trauma-informed care and reducing stigma
- Adequate and sustainable funding

Priority Strategies

- Increase access to emergency department interventions that include MOUD, peer support, discharge planning, and recovery case management or supportive services.
- Expansion of warm hand-off programs (Project Hope, Behavioral Health and First Responder co-response)

Evidence Based Treatment

Current Gaps

- Limited availability of community triage and stabilization centers that include peer support, detox, and referrals to services
- Methadone providers and same-day access to medications
- MOUD services for youth, rural communities, and sustainable programming in jails
- Services with immediate access to treatment, including high barriers for:
  - Youth
  - People with co-occurring SUD and mental illness
  - People not criminal justice-involved
  - Fathers with children
  - People insured through OHP

Priority Strategies

- Increase inpatient/residential treatments and MOUD community resources in community (health systems, mobile units, justice settings)
- Provide additional access to evidence-based withdrawal management services
- Support crisis stabilization centers that serve as an alternative to EDs for persons with substance use disorders, co-occurring mental health conditions, and those who experience an overdose

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.